NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PURCHASE OF MEDICAL CARE SERVICES PAYMENT PROGRAMS
April 2008

Permanent residents of North Carolina who are medically and financially eligible may receive assistance through the following programs if other health coverage is limited or unavailable:

Children's Special Health Services
Infant Toddler
Early Hearing Detection & Intervention
Adult Cystic Fibrosis
Sickle Cell Syndrome
Cancer Control
Kidney
HIV Medications
Migrant Health Program

CHILDREN'S SPECIAL HEALTH SERVICES (CSHS) is available to Medicaid eligible children with special health care needs up to the age of 21 if the child has a disease or chronic condition supported by the program.

Eligibility: Medicaid eligibility qualifies patients financially for CSHS. Under a special provision offered by the program, adopted patients at or below the federal poverty level may be eligible for CSHS without qualifying for Medicaid and without considering the adoptive parents' income. Application to CSHS must be processed before the child's adoption.

Covered Services: For Medicaid eligible children, CSHS pays for durable medical equipment, oral formula *(Note: POMCS coverage for oral formula ends 6/30/08),* condition-related over the counter drugs and supplies and some orthodontic care. Non-Medicaid eligible children with special post-adoption coverage are also covered for inpatient admissions, outpatient care, physician's office visits, special therapies, prescription drugs***. Note: Requests for DME and DME supplies that do not require prior approval review by CSHS, and are included in Medicaid's DME fee schedule will be denied by CSHS. These types of requests should go directly to Medicaid.***

Additional Information: Client and Provider Liaison 1-800-737-3028

INFANT TODDLER PROGRAM (ITP) is a program which provides early intervention services to children with special needs from birth to age 3. These services are provided by many different agencies including Children's Developmental Services Agencies (CDSA's), specialty providers, and service coordinators. Children with developmental delays, atypical development or those who are considered high risk may qualify for the program. Service recommendations for the child are determined by the Consortium which consists of but is not limited to providers, the local mental health agency, the health department or Children's Developmental Services Agencies, parent of the child with special needs, and the Service Coordinator. The Service Coordinator is responsible for completing the Individual Family Service Plan (IFSP) and coordinating services that the child is to receive.

Additional Information:

For information on covered services and eligibility requirements please contact the Family Support Network of North Carolina or someone at one of the Children's Developmental Services Agencies. Additional information as well as contact information can also be found on the North Carolina Early Intervention web site http://www.ncei.org/ei/index.html.

Early Hearing Detection & Intervention (EHDI) is available to children from birth to age 3 who are not enrolled in EI and do not have Medicaid coverage.
Eligibility: No income eligibility requirements and no clinical prior approval required.
Covered Services: Initial hearing aids, earmolds, hearing aid batteries, care kits and dispensing fees.
Additional Information: Client and Provider Liaison 919-707-5632

ADULT CYSTIC FIBROSIS PROGRAM is available to persons with the diagnosis of Cystic Fibrosis, ages 19 and older.
Eligibility: Net family income at or below 100% of the federal poverty level.
Covered services: Inpatient admissions, outpatient care, physician's office visits, durable medical equipment, formula, special therapies, condition-related drugs and supplies.
Additional Information: Client and Provider Liaison 1-800-737-3028

SICKLE CELL PROGRAM covers persons of any age with Sickle Cell Syndrome or Sickle Cell Disease.
Eligibility: Net family income at or below 100% of the federal poverty level.
Covered Services: Inpatient care (7 day maximum per year), outpatient care, emergency room visits up to 12 per year, physician's office visits, drugs on the program formulary, durable medical equipment, special therapies, condition-related supplies, preventive and maintenance dentistry. Eye care is covered if it is not available through Services for the Blind. ***Note: Program no longer covers obstetrical, psychiatric or psychological care.***
Additional Information: Program Manager 919-707-5705

CANCER PROGRAM covers medical care related to the diagnosis and treatment of cancer. If a person has a condition suspicious of cancer, the program will pay for up to 8 days of service per year to diagnose or rule out the disease. If a person is diagnosed with cancer and has a 25% or better chance of five year survival based on the National Cancer Institute SEER data, the program will pay for up to 30 days of treatment per year. The program also covers 2 days per year for follow-up visits if the diagnostic and treatment limits have not been met. Reimbursement for any professional fee, outpatient service, or inpatient admission is limited to 1% of the program's annual budget.
Eligibility: Gross family income at or below 115% of the federal poverty level.
Covered Services: Inpatient admissions, outpatient care, physician's office visits, short term motel stays and meals for patients undergoing program funded treatment in a facility that is over 50 miles from home.
Additional Information: Program Liaison 919-707-5321
Website: http://www.communityhealth.dhhs.state.nc.us/cancer.htm

KIDNEY PROGRAM covers persons with End Stage Renal Disease who require dialysis or transplantation.
Eligibility: The program's income scale was established by the state legislature some years ago and does not reflect the current federal poverty level. Patients may apply at any time during the year. Reapplications are processed April through June for the 12 month period beginning July 1.
Covered Services: Chronic maintenance dialysis, home training dialysis, inpatient hospital dialysis, condition-related drugs and supplies. Payment for drugs and supplies is limited to $300 per year.
Additional Information: Program Liaison 919-707-5321

HIV MEDICATIONS PROGRAM covers medications for persons with HIV or AIDS who are not covered by Medicaid or insurance

Eligibility: Net family income at or below 250% of the federal poverty scale. Patients may apply at any time during the year. Reapplications are processed January through March for the 12 month period beginning April 1. *Note: The program sometimes maintains a waiting list due to excessive demand for funding.*

Covered Services: FDA approved anti-retroviral drugs and other drugs for the treatment of associated medical conditions. The program's current formulary is found on the website

Additional Information: Program Manager 919-715-3111,
Website: http://www.epi.state.nc.us/epi/hiv/

MIGRANT HEALTH PROGRAM provides coverage for basic preventive health services and primary care to migrant farm workers and their dependents.

Eligibility: Applicants must live in North Carolina and meet the federal definition of a migrant farm worker by having worked in agriculture and relocated during the past 24 months. Dependents of migrant farm workers also qualify. A Migrant Health Fee-for-Service Eligibility Application must be completed annually. Once determined, program eligibility extends for a 12 month period. There are no financial eligibility criteria for program coverage.

Covered Services: Primary care, outpatient care, physician's office visits, laboratory tests, diagnostic x-rays, drugs covered under the formulary, medical supplies, and limited mental health services. Dental coverage includes basic preventive, diagnostic, simple restorative and limited surgical procedures. Requests for durable medical equipment, therapies and home health services are reviewed on a case by case basis by the Program Manager. With the exception of DME, supplies and drugs, coverage is limited to $150 per provider per date of service. Patient co-payments are set at $5 for medical and dental visits and $6 for prescriptions, over the counter drugs, and durable medical equipment. A current Migrant Health Formulary may be found on the Purchase of Medical Care Services website.

Additional Information: Program Manager 919-733-2040, ext. 233

RESIDENCY

North Carolina residency is based on the applicant's intent to make his permanent home in the state and his legal ability to make that statement. Residency is determined by meeting one of the following criteria:

- Patient, or parent of a minor patient, is a U.S. citizen who lives in North Carolina and intends to make North Carolina his/her permanent home.

- Patient, or parent of a minor patient, is not a U.S. citizen, but has applied for U.S. citizenship. INS documentation must accompany the application.

- Patient, or parent of a minor patient, is not a U.S. citizen but has a permanent resident visa or has applied for one. INS documentation must accompany the application.

  Exception for the HIV Medications Program only: Patient lives in North Carolina and declares North Carolina to be his/her primary residence.

- Patient is a migrant farm worker or a dependent of one according to the federal definition of migrant farm worker status. A Migrant (Farm worker) Health Program Eligibility Application (DHHS 3753) must be submitted.
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  Migrant farm worker status qualifies the applicant as a North Carolina resident for all POMCS programs.

FINANCIAL ELIGIBILITY

Eligibility determination is the first step in POMCS' three-step process, which includes authorization of services and claims payment. The purpose of the process is to assess an applicant's ability to pay for medical care using program guidelines and income scales. **With the exception of the Children's Special Health Services and Migrant Health programs, patients must have a Financial Eligibility Application (DHHS 3014) completed annually by a financial interviewer.** Staff in physicians' offices, hospitals and health departments serves as interviewers as do representatives of designated community service agencies. Instructions on how to complete the application are provided on the back of the form.

Once determined, financial eligibility generally extends for a 12 month period. Applicants to the HIV Medications and Kidney programs may be covered for up to 15 months, if their applications are received during the final quarter of the program year.

The following information is intended to help interviewers complete this form and thereby expedite authorization processing and claims payment.

FAMILY MEMBERS

In completing the income portion of DHHS 3014, the interviewer must first identify the patient and assess the number of persons in the patient's household. **Block 14 on the eligibility application is intended to reflect the number of countable household**

members. This figure may in fact differ from the number of persons actually residing in the home.

Family members are those people who satisfy <u>ALL THREE</u> of the following categories:

- Related to the patient by blood, marriage or adoption
- Live in the same household as the patient
- Financially responsible for the patient or the patient responsible for them

With these standards in mind, **if the patient is less than 18 years old <u>and</u> unmarried, the following persons should be counted:**

PATIENT

PARENTS OF THE PATIENT

STEPARENTS OF THE PATIENT … If they do not have income

SIBLINGS OR HALF SIBLINGS OF THE PATIENT
… If they are unmarried and less than 18 years old
… If they are 18 years or over and have no income
… If they are married and neither they nor spouse have income

STEPSIBLINGS OF THE PATIENT … If they are without income **and** their Biological parent is counted

OTHER INDIVIDUALS living in the household who are related to the patient by blood, Marriage or adoption **and** do not have any income. Other individuals are not counted if they have a parent or spouse with income living in the same household.

The term 'other individuals' refers to members of the patient's extended family. Grandparents, great grandparents, aunts, uncles, cousins, siblings, nieces and nephews are included in this category.

If the patient is 18 years or over <u>or</u> less than 18 and married, the following persons should be counted:

PATIENT

SPOUSE OF PATIENT

CHILDREN OF PATIENT
… If they are unmarried and less than 18 years old
… If they are 18 years or over and have no income
… If they are married and neither they nor spouse have income

STEPCHILDREN … If they have no income

PARENTS OF THE PATIENT **…**If they live with and are supported by the patient

OTHER INDIVIDUALS living in the household who are related to the patient by blood, Marriage or adoption **and** do not have any income. Other individuals are not counted if they have a parent or spouse with income living in the same household.

FREQUENTLY REFERENCED HOUSEHOLD SITUATIONS

If the patient is a child who is not living with his/her parents, the child should be counted as a family of one, since he is not living with a relative who has legal responsibility for his financial support. Neither relatives nor legal guardians should be counted.

If the applicant was recently married, the spouse's income from the past year should be included even though the two were not living together during the entire 12 months.

If the family has separated, only the income of the family members who live with the patient at the time of application should be counted.

Assistance payments and child support are included or excluded as indicated above.

Adopted children are treated as biological children and counted as family members: Children with special post-adoption coverage through CSHS are counted as families of one.

If the family includes a student who is living away from home while attending school, the student is considered to be living in the permanent home.

A common law spouse is not counted as a family member.

If an applicant is the legal guardian to a minor, the child is regarded as an "other individual" and counted as a family member if he/she has no income.

A spouse with income who permanently resides in a nursing home is not counted as a family member.

INCOME

In determining income, it is important to remember that a person's income must be counted if he is counted as a family member.

Sources of Income

Income from the following sources should be counted:

- Salaries and wages
- Earnings from self-employment
- Interest earned on investments
- Periodic trust fund payments
- Payments from pensions and retirement accounts
- Workers' Compensation
- Educational stipends in excess of the cost of tuition and books
- Income tax refunds *

- Public assistance money
- Unemployment compensation
- Alimony and child support payments
- Military allotments
- Allowances paid for basic living expenses
- Social Security benefits
- Veteran's Administration benefits
- All other sources of cash income except those specifically excluded

** Does not apply to the Cancer Control Program, which is based on gross income.*

Income from the following sources should **not** be counted:

- Irregular income that a child earns from babysitting, lawn mowing, or other tasks
- Proceeds from the sale of an asset
- Withdrawals from a bank account
- Gifts
- Inheritances
- Life insurance proceeds or one time settlements

Computation of Income:
Gross family income is computed by adding money earned/received by countable family members during the appropriate 12 month period. Net family income equals that amount minus allowable deductions.

The start date for calculating income is based on the date of application or the requested date of service, whichever is earlier. If the requested date of service precedes the date of application, income data in Block 16 should reflect the adjusted time frame and Block 17 should include an explanation to that effect.

Using the appropriate start date, the **REGULAR INCOME FORMULA** is applied when wage earners were continuously employed during the previous 12 months **or** when the source of unearned income was consistent during the previous 12 months. To calculate income based on this formula:

ADD: Income received during previous 12 months

SUBTRACT: Allowable deductions from previous 12 months

The **UNEMPLOYMENT INCOME FORMULA** is an alternative method of calculating income. The purpose of the formula is to allow for changes in income that effect an applicant's ability to pay for medical care**. It must be used when wage earners are unemployed on the start date or have been unemployed for at least 30 consecutive days during the previous 12 months.** This formula is also used when the applicant has transitioned from earned to unearned income/unearned to earned income (Unemployment, Social Security, retirement or assistance payments) **or** when earnings have increased/decreased due to a change in job or work schedule. To calculate income based on this formula:

ADD: Actual income earned during previous six months
Projected income for future six months

SUBTRACT: Medical expenses paid or incurred during the past 12 months
Allowable non-medical expenses from past six months and those projected for the future six months if known. If future deductions are not known, substitute expenses from the past 12 months.

When the Financial Eligibility Application is completed in advance of service delivery, the projected income is based on the patient's most recent or anticipated salary. In cases where the application is completed after-the-fact, 'future six months' may reference actual as opposed to projected earnings. Projected income may equal zero. When the Unemployment Formula is used, the interviewer should specify the dates of unemployment or transition in Block 17.

Computation of Net Income:
When computing income, frequency of pay is a consideration. Gross income is calculated as follows:

Weekly	=	pay X 52
Biweekly	=	pay X 26
Twice a month	=	pay X 24

To arrive at a net income figure, subtract federal and state income taxes, social security withheld from the applicant's salary and any other deductions allowed by Purchase of Medical Care Services.

Using Tax Returns
When computing income using tax returns, refer to the forms as follows:

GROSS INCOME
The applicant's gross income is determined by referencing the line that is labeled 'total income' on federal Form 1040. **For those who are self employed or who farm, allowable expenses/losses are included in this figure.** The comparable figure on Form 1040 EZ is labeled 'adjusted gross income'.

NET INCOME
If the program is based on net as opposed to gross income, the applicant may deduct the income taxes referenced on the 'total tax' lines of federal Form 1040 and state Form D-400.

Social Security Withholdings
This amount is determined by referencing the applicant's paycheck stub or W-2.

Zero Income
If the patient reports zero or very little income, the interviewer should include an explanation of how the person or family is actually living in Block 17 of the eligibility application. In most cases, a statement of zero income is acceptable only when the applicant lives on income from sources not counted by Purchase of Medical Care Services.

Whenever an applicant's family situation or income changes, a new application should be completed.

DOCUMENTATION OF INCOME

Documentation of earned income is required in the following situations:

- When coverage for inpatient services is requested
- When medical expense deductions exceed $3,000
- When the financial interviewer questions the applicant's income statement
- When the Purchase of Medical Care Services requests documentation

Acceptable forms of documentation include:

- Pay check stubs
- W-2 forms or 1099's
- Income tax returns and attachments for the most recent calendar year
- Written statements from employers when the above mentioned items are unavailable

Although documentation of income is not required of every applicant, interviewers may opt to request it. Documentation increases the accuracy of income calculations and eliminates the need to request additional records in the event of an inpatient admission. It also minimizes the chances of eligibility being granted on the basis of declared income and subsequently terminated when documentation is submitted.

When the situation warrants documentation and the family consists of more than one wage earner, each one must document his/her income. If a tax return is submitted as documentation, all related schedules must be attached.

ALLOWABLE DEDUCTIONS

With the exception of the Cancer Control Program, a variety of medical and non-medical deductions are available to applicants:

Federal and state income taxes

Social Security withholdings

Mandatory payroll deductions

Work-related expenses

Health insurance premiums

Child day care expenses for any child less than 15 years of age and for any handicapped child regardless of age, if both parents/a single parent work or are disabled.

Child support or alimony paid to support someone outside of the applicant's household.

Expenses for the care of a spouse who is physically or mentally unable to take care of himself while the other spouse is at work.

Educational expenses incurred for the purpose of managing the disability of any member of the patient's family.

Medical expenses, which fall into any of the following categories, may be deducted from the family's income:

- Medical and dental expenses paid/incurred by any family member during the previous 12 months that were not covered by insurance, Medicaid or Medicare and are not being requested through POMCS programs.
- Payments made to medical and dental providers by the applicant or his family during the previous 12 months for services received more than 12 months ago.
- Cost of transportation required to obtain medical and dental care based on the state's rate of reimbursement, which is currently 36.5 cents per mile.

The Financial Eligibility Worksheet (DHHS 3017) is available to interviewers as a tool for calculating income and deductions.

DOCUMENTATION OF MEDICAL DEDUCTIONS

Documentation of medical expenses is required if medical deductions exceed $3,000 and is usually requested if the applicant has insurance or other third party coverage. Additionally, the financial interviewer or Purchase of Medical Care Services staff may request documentation whenever deductions are questionable.

To simplify the process, it is recommended that interviewers document only those expenses that are required to meet the program's income guidelines and that they use the oldest and largest applicable payments and/or bills when calculating eligibility.

The best forms of documentation are copies of medical bills, receipts, canceled checks or insurance statements. Documents that do not specify dates of service and payment may be rejected. In cases where documentation is not available, POMCS may accept a statement of medical expenses, which includes the following information:

- Date of service
- Provider's name
- Amount of bill
- Amount paid by other third parties
- Amount patient owes after other third parties have paid

The Medical Expense Worksheet (DHHS 3726) may be required for reporting medical deductions of $3,000 or more. The worksheet presents an applicant's expenses in a workable format and assists interviewers and Purchase of Medical Care Services staff in assessing financial eligibility.

INCOME SCALES

Once the patient's income has been computed, financial eligibility is determined by referencing the program's income scale. It is generally appropriate to utilize the current scale. However, **when an application is filed retroactively, it may be necessary to reference an earlier scale to accommodate the requested dates of service.** Income scales are updated annually and are posted on the POMCS website. The website address can be found on the last page of this manual.

OVER INCOME APPLICANTS

An interviewer, who determines an applicant to be over income, need not submit the application to POMCS unless it is necessary to verify or document a patient's ineligibility.

SPENDDOWNS

On occasion, an applicant's income exceeds program limits, but subsequent medical expenses result in additional deductions. When a hospitalization is involved, a copy of the hospital and physician's bills showing daily charges must be submitted with the Financial Eligibility Application. Program coverage begins the day after the medical expense deduction is met. The patient is financially responsible for charges incurred prior to program eligibility, but the remaining days of the admission may be covered.

INSURANCE

The Financial Eligibility Application (DHHS 3014) should include the following information about the patient's health insurance coverage:

- Insurance company name
- Policy number
- Insurance company address and telephone number
- Whether or not the patient is covered by the policy
- Whether or not the coverage is an HMO or prepaid plan
- Any known waiting period requirements or benefits exclusions

Even if the patient is not covered by the policy, the family's health insurance information should be recorded on the Financial Eligibility Application, since this information assists Purchase of Medical Care Services in verifying medical expense deductions. It is likewise helpful in determining when the patient meets the waiting period requirements for pre-existing conditions.

REPLY TO FINANCIAL ELIGIBILITY APPLICATIONS

Purchase of Medical Care Services has 45 days to process Financial Eligibility Applications. Following the review of CSHS Post Adoption Coverage, Adult Cystic Fibrosis, Cancer and Sickle Cell applications, a system generated Reply to Financial Eligibility Application is sent to the applicant and the financial interviewer if the applicant is found to be either eligible or ineligible for program coverage. The reply specifies the applicant's eligibility status as well as the range of covered dates and categories of care.

When the eligibility application is incomplete, a Request for Additional Information/Denial of Financial Eligibility (DHHS 3053) is sent to the applicant and the financial interviewer. This form specifies the information or documentation that must be received before eligibility can be determined. Interviewers must respond to this request within one year after the date of service or within 30 days of notification, whichever is later.

System generated replies are not utilized by the HIV and Kidney programs at this time. In these cases, POMCS responds in one of two ways. If the application is incomplete or the patient is ineligible, a 3053 form is sent to both the patient and the interviewer. If the patient is determined eligible, eligibility is incorporated into the authorization process.

AUTHORIZATION REQUESTS

Authorization of services is the second step in POMCS's three-step process. Once a patient is determined financially eligible, requested services must be approved before payment can be made. To request a service, providers must submit an Authorization Request (DHHS 3056 or 3056adap) to Purchase of Medical Care Services. The request must be received within one year after the date of service. Detailed instructions on how to complete the request are provided on the back of the form**. With the exception of Migrant Health, all POMCS administered programs utilize the authorization request**.

Within 45 days after receipt, POMCS will process the request and generate replies.

When completing an Authorization Request, it is important to remember the following:

- Separate forms must be completed for each type of service
- Inpatient admissions must be requested individually
- Requested service should correspond to diagnosis
- All programs do not cover all types of service
- Programs have specific guidelines related to signatures and documentation
- Programs limit the number and duration of services which can be requested on one form:

CHILDREN'S SPECIAL HEALTH SERVICES PROGRAM

1. Drugs and Supplies – 1 year
2. Orthodontic Services – 1 year
3. Oral Formula – 1year

CSHS POST ADOPTION COVERAGE/ADULT CYSTIC FIBROSIS/SICKLE CELL

1. Inpatient Admission – 30 days (7 day maximum per year for Sickle Cell)
2. Inpatient Extension – 30 days (N/A for Sickle Cell)
3. Outpatient Surgery – 1 day
4. Hospital Outpatient Visits – 36 at 3 per week for 3 months
5. Physicians' Office Visits – 36 at 3 per week for 3 months
6. Therapy Sessions (P.T. , O.T, Speech) – up to 240 units for a 6 month period
7. Drugs and Supplies – 1 year
8. Orthodontic Services – 1 year (not covered by Sickle Cell)
9. Rental of Equipment – 6 months
10. Hearing Aid Parts and Accessories – 1 year (not covered by Sickle Cell)

CANCER PROGRAM

1. Diagnosis – 8 days of inpatient or outpatient services (July 1 – June 30)
2. Treatment – 30 days of inpatient or outpatient services (July 1 – June 30)

KIDNEY PROGRAM

1. Dialysis – 1 year (July 1 – June 30)
2. Drugs – 1 year (July 1 – June 30)

HIV MEDICATIONS PROGRAM – Drugs – Up to 1 year

HMO Participation

When the patient is an HMO participant, a denial or statement of benefits must be submitted. Although requests will not be processed until policy information is received, authorization requests should be forwarded without this documentation, if necessary to meet deadlines.

Reply to Authorization Request

When completing an Authorization Request form, the requesting office should make every effort to include all providers involved in the delivery of the requested service. Once a request has been processed, a reply is sent to all parties listed in blocks 15, 25 and 29 (DHHS 3056). Program participants also receive replies.

The reply indicates that the service has been approved, denied or pended. It includes information that providers will need to submit a claim or alerts them to the need for additional information or documentation. Providers are encouraged to review the reply carefully and to bill or respond on a timely basis. If additional information is requested, providers must respond within 1 year after date of service or within 30 days of notification, whichever is later. On occasion, a Reply to Request for Service (DHHS 4038) will be substituted for the Reply to Authorization Request.

Providers who are not included on the Authorization Request form or who fail to receive a reply may also submit claims. They can access the necessary information by contacting another provider or the POMCS Authorization Unit.

Request for Change

A service that has been authorized is sometimes subject to change. To initiate that process, the provider identified in Block 26 of the authorization request (DHHS 3056) must submit a written statement to POMCS. A copy of the original authorization should accompany the request for change.

For the Infant Toddler Program only the Financial Officer can initiate such a request. To request a change the Financial Officer must write “Amended” at the top of either the original request or the Reply to Authorization Letter. Upon making the change, the Financial Officer must also sign and date the amended request.

When completing Financial Eligibility Applications and Authorization requests, financial interviewers and requesting office contacts should make special note of the following:

- It is critical that forms be legible as well as complete when submitted to Purchase of Medical Care Services. The names and phone numbers of financial interviewers and requesting office contacts are of particular importance.
- If an eligibility application, request and claim are submitted simultaneously, the forms should be ordered as required for processing.
- Forms and documentation that are faxed to Purchase of Medical Care Services are not expedited unless arrangements have been made with a staff member.

- Block 17 of the Financial Eligibility application should be used to provide POMCS staff with any additional information that was considered in completing the form.

Explanations related to family size, employment, income, insurance and dates of service are encouraged. Failure to include this information may delay the approval process.

- The availability of other insurance coverage is important to POMCS as relates to both the authorization of services and the payment of claims. In completing block 21 of the Financial Eligibility Application and Block 19 of the Authorization Request, it is important to include complete policy information. If the patient is enrolled in an HMO or covered by a managed care policy, this distinction should be made at the time of application.

DISCLAIMER

Please keep in mind that it is the ultimate responsibility of the interviewer and or providers of services to ensure that Purchase of Medical Care Services has received the Financial Eligibility Application, Authorization Requests and all related claims along with any other pertinent and required documents. Purchase of Medical Care is not responsible for lost or misdirected document submissions. If you have not received a response after 45 days of submission please follow up with either the requesting office or Purchase of Medical Care Services.

Financial Eligibility Applications and Authorization Requests should be submitted to:

Purchase of Medical Care Services
DHHS-Division of Public Health
1904 Mail Service Center
Raleigh NC 27699-1904

CLAIMS PROCESSING

CLAIMS SUBMISSION

To qualify for payment, the patient must be eligible for the program, the requested service must be authorized and the related claims must be received within one year after the date of service, or within 45 days after the date of authorization, whichever is later. **All claims should include the patient's case number authorization number and billing provider's Medicaid provider number.**

Within 45 days after receipt, POMCS will process the claim, generating either payment or a reply. The Reply to Claim (DHHS 3741) will deny or specify the status of the unpaid claim. Corrections to claims and requests for payment adjustments must be received by POMCS within 1 year after date of service or within 45 days after the claim is paid or returned for additional information, whichever is later.

TYPES OF CLAIMS

Hospital and other institutional services must be billed on a UB-92.

Professional fee claims must be submitted on the HCFA 1500 for all types of service. The exception is dental services which should be billed on the current ADA form.

Durable medical equipment, supplies, and orthodontic claims must be billed on the HCFA 1500. The date of delivery or service must be given and the appropriate procedure code with description must be entered for each item. Quantities must be specified for supplies such as diapers, formula, syringes etc... A DME Billing Guide is available upon request.

Pharmacies must bill prescription drugs on the Pharmacy Claim (DHHS 3058). Durable medical equipment, supplies, and formula must be billed on the HCFA 1500 with the appropriate procedure code entered. Over-the-counter items may be billed on the DHHS 3058 or the HCFA 1500.

Speech therapy, physical therapy and occupational therapy claims must be billed separately on the HCFA 1500 claim form. The UB-92 claim form is used for hospital based therapies.

REIMBURSEMENT

The payment programs usually reimburse providers at the Medicaid rate, but there are some exceptions. **If payment from the Department is accepted for a service, the provider may not charge the patient the difference between the payment and the provider's usual charge.**

THIRD PARTY RECOVERY

- Providers must bill other third party payers and wait up to 6 months after date of service for a reply from third party payers before billing Purchase of Medical Care Services.
  Note: Providers of outpatient pharmacy services are required to bill Medicaid but not

other third party payers. Any third party payers payment must be disclosed on the pharmacy claim form.

- Providers paid by Purchase of Medical Care Services are required to make reimbursement within 45 days if they subsequently receive payment from another third party.

COORDINATION WITH OTHER THIRD PARTIES

If the patient has other third party coverage, the provider must first bill the other carrier and wait up to 6 months after the date of service to receive payment or denial before billing Purchase of Medical Care Services. Other third party coverage includes but is not limited to insurance, Medicaid, Medicare and CHAMPUS.

If the other third party pays the claim within 6 months after service, the amount paid should be indicated on the claim and the claim submitted to POMCS. The Claims Processing Unit will determine the maximum allowable payment rate for the service, subtract the amount already paid by other payers, and pay the difference up to the maximum reimbursement rate. If other third parties have paid more than POMCS' maximum rate, no additional payment will be made.

Example #1:	$100.00	Maximum payment rate
	- 80.00	Insurance payment
	$ 20.00	POMCS payment

Example #2:	$100.00	Maximum payment rate
	-120.00	Insurance payment
	$ 0.00	POMCS payment

If the other third party payer denies payment, providers should submit the claim to POMCS and attach a copy of the denial, including the explanation. The maximum reimbursement rate will be paid if the third party payer denied payment because the patient has not met his deductible or because the service is not covered. POMCS will deny payment if insurance normally covers the service but did not pay because the provider failed to obtain prior approval or because the patient did not use an in network approved provider with their third party carrier.

If the other third party does not respond within six months, providers should indicate the date insurance was billed and state that no response has yet been received. The claims should be submitted to POMCS for processing.

Providers who are paid by POMCS and subsequently receive payment from another third party payer are required to reimburse POMCS within 45 days. Reimbursement should equal the lesser of the two payments received.

Example #3:	$ 70.00	POMCS payment to provider
	$ 60.00	Insurance payment received later
	$ 60.00	Refund due to POMCS within 45 days

Example #4:	$ 70.00	POMCS payment to provider
	$ 90.00	Insurance payment received later

$ 70.00 Refund due to POMCS within 45 days

If the patient's other coverage is an HMO, he must go to an HMO provider for medical care. The HMO provider may not bill POMCS for services covered under the patient's plan. If the service is not covered under the patient's plan, a claim accompanied by an HMO denial may be submitted. If the patient is insured by a managed care policy that pays a percentage of charges, Purchase of Medical Care Services' third party standards as referenced in examples #1 and #2 apply.

Claims should be submitted to:

Purchase of Medical Care Services
CLAIMS PROCESSING UNIT
1904 Mail Service Center
Raleigh N.C. 27699-1904

DISCLAIMER
Please keep in mind that it is the ultimate responsibility of the interviewer and or providers of services to ensure that Purchase of Medical Care Services has received the Financial Eligibility Application, Authorization Requests, and all related claims along with any other pertinent and required documents. Purchase of Medical Care is not responsible for lost or misdirected document submissions. If you have not received a response after 45 days of submission please follow up with either the requesting office or Purchase of Medical Care Services.

PURCHASE OF MEDICAL CARE SERVICES TIME FRAMES

Financial Eligibility Applications

- Must correspond to requested date(s) of service
- Include income information for 12 months prior to date of signature or 6 months prior and 6 months projected if 30 consecutive days of unemployment are involved
- Are processed within 45 days
- May require additional information to be submitted within 1 year after date of service or within 30 days of notification, whichever is later.
- Are good for 1 year if approved

Authorization Requests

- Are subject to program limitations regarding number/duration of services which can be approved
- Must be received within 1 year after date of service
- Are processed within 45 days after receipt
- May require additional information to be submitted within 1 year after date of service or within 30 days of notification, whichever is later
  Are approved or denied within 45 days after receipt of all necessary information

Claims

- Must be received within 1 year after date of service or within 45 days after date of authorization, whichever is later.
- Will be processed within 45 days after receipt of completed claim form.
- re processed within 45 days after receipt of completed claim form
- Must be corrected within 1 year after date of service or within 45 days after return for additional information, whichever is later
- Adjustments must be received within 1 year after date of service or within 45 days after claim is paid, whichever is later.

FORMS

Forms can by downloaded from the Purchase of Medical Care web site as indicated below. If access to the website is not available the forms may be ordered by faxing a DHHS 3202 to 919-733-0352 or mailing the order to Purchase of Medical Care Services. Mail orders should be submitted to the address below and should include your name, mailing address, courier number if available, the program you are ordering forms for and the quantity needed.

Purchase of Medical Care Services
DHHS Division of Public Health
1904 Mail Service Center
Raleigh NC 27699-1904

CONTACT INFORMATION

Purchase of Medical Care Services ……..919-855-3700

Financial Eligibility/Authorizations/Provider Relations

Financial Eligibility and Authorization Status Inquiries
919-855-3701
919-715-3848 (Fax)

919-715-5221
(HIV Medications Program Fax)

Unit Supervisor
Danny Ellis
919-855-3650

Provider Relations Manager
Rhonda Moyer
919-855-3651

Authorization Unit Supervisor
Sue Harrington
919-855-3652

Claims
Claims Inquiries
919-855-3702
919-733-0352 (FAX)

Branch Head
Bob Duke
919-855-3735

Claims Unit Supervisor
Kim Papa
919-855-3653

POMCS WEBSITE
www.ncdhhs.gov/control/pomcs/pomcs.htm